Patient-Centered Medical Homes

EXHIBIT NO. 1
DATE 1.23.12
BILL NO. SB 84

SB 84 · Section-by-Section Summary

Section 1 Legislative findings. The Patient Centered Medical Home Advisory Council (PCMH) studied the PCMH concept for two years, and these findings represent the unanimous opinion of the council regarding the benefits of the PCMH program. The council consists of representatives from insurers, self-funded health plans, Medicaid, hospitals, community health centers, and a variety of health care providers. PCMHs promote and facilitate the delivery of primary care and preventative healthcare services, which also reduces overall costs by reducing hospital admissions and emergency care. The proposed findings conclude that PCMHs save health care costs by greatly improving the coordination of the delivery of healthcare services, in particular care for chronic diseases. The PCMH program is attractive to primary care physicians because it promotes efficiency, recognizes the important role of primary care providers, and serves as a way to effectively manage healthcare delivery in a rural state. A uniform definition and set of quality measures is necessary to the success of a PCMH program.

Section 2 Commission for patient-centered medical homes established – purpose. This section establishes a commission to oversee the adoption of PCMH standards and the qualification of patient-centered medical homes. **The commission provides the PCMH oversight function, which is a necessary element of the state action doctrine for anti-trust immunity.** Anti-trust protection is necessary to protect insurers and healthcare providers from potential lawsuits brought by competitors.

Section 3 Definitions. This section supplies the necessary definitions for the PCMH program, including the definition of "health plan" and the definition of "primary care practice." The provisions of this bill apply to health plans issued by all types of licensed insurers, including MEWA's. Self-funded health plans may participate through their third party administrators. Self-funded government health plans like the state health plan and public health programs like HMK and Medicaid are also included in this bill, even though they are not included in the health plan definition. "Primary care practice" is defined to include different types of providers. Health plan and healthcare provider participation in the PCHM program is always voluntary.

Section 4 Board of directors—composition—appointment—compensation. The board of directors has nine members: five appointed by the commissioner and four appointed by the governor. The board members consist of representatives from health plans (2), consumer organizations (3), primary health care providers (3), and the state health plan (1). The governor and the commissioner each have a non-voting representative on the board. The governor's representative must be from the Medicaid division.

Section 5 Powers and duties of the commissioner – rulemaking. The commissioner shall approve or disapprove any participant fees the commission may propose to fund the activities of the commission, receive and investigate any complaints about the commission, and adopt rules if necessary. No general fund money will be used to fund this program.

Section 6 Powers and duties of the commission. The commission shall set standards for patient-centered medical homes, qualify patient centered medical homes that meet the standards, promote the use of patient-centered medical homes in Montana, and evaluate and report on healthcare cost savings and patient satisfaction achieved by the PCMH program. The commission must consult continuously with all interested parties—health plans, insurers, healthcare providers, etc. regarding all decisions made by the commission.

Section 7 Standards for Patient-centered medical homes. Standards may be set in following areas: payment methods (i.e. practice transformation costs and care coordination fees; the fee-for-service payment structure remains intact); bonuses and incentives for reaching goals of improved health outcomes and cost savings; uniform health care quality and performance measures; and uniform measures related to cost and medical usage. This section also sets forth the reporting requirements for PCMH healthcare provider practices and lists who will receive the reports. PCMH's will report on their compliance with the uniform set of health care quality and performance measures to health plans, the commission and DPHHS (if participating). Health plans must report on their compliance with the standards to the PCMH provider groups. Participation in the PCMH program is always voluntary. However, if a payer or healthcare provider wishes to create a PCMH, it must follow the standards set by the commission and utilize only PCMH provider groups that have been qualified by the commission.

Section 8 Section 20-25-1403, MCA is amended to specify that the PCMH statutes apply to any self-funded student health plan that may be created in this state.

Section 9 Section 33-1-102, MCA is amended to specify that the PCMH statutes apply to HMO's and self-funded student health plans.

Section 10 Section 33-31-111, MCA is amended to specify that the PCMH statutes apply to HMO's.

Section 11 Section 33-35-306, MCA is amended to specify that the PCMH statutes apply to Multiple Employer Welfare Arrangements (MEWA's).

Section 12 Section 53-6-113, MCA is amended to specify that the Department of Health and Human Services may adopt rules to create a PCMH program for Medicaid. PCMH program adoption is not mandatory, but if Medicaid does create a PCMH program, it must use PCMH healthcare practices that have been qualified by the commission. However, Medicaid does not have to follow the PCMH standards adopted regarding the payment structure for a PCMH.

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